

## Office of Human Resources • Medical Inquiry for Accommodation Request

Employee First Name:

Employee Last Name:

Employee NSU ID:

### Instructions to the Health Care Provider

A request for a reasonable accommodation has been made by the employee identified above. In order to assist with the interactive process, we are requesting that you provide answers to the following questions based on your medical expertise. The medical documentation you provide should identify the disability, the major life activity that is affected and how it impacts your patient at work so that solutions can be explored. With this in mind, please review the enclosed job description and identify the specific duties impacted by your patient's medical condition and describe how the medical conditions causes work-related problems.

Does the employee have a physical or mental impairment?

Yes  No

If yes, what is the impairment or nature of the impairment?

Does the employee's impairment substantially limit a major life activity or major bodily functions as compared to most people in the general population?

Yes  No

If **major life activity** or activities are affected, please select the activities from the menu below.

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Bending                   | <input type="checkbox"/> Breathing                 | <input type="checkbox"/> Self-Care |
| <input type="checkbox"/> Concentrating             | <input type="checkbox"/> Eating                    | <input type="checkbox"/> Learning  |
| <input type="checkbox"/> Hearing                   | <input type="checkbox"/> Interpersonal Interaction | <input type="checkbox"/> Lifting   |
| <input type="checkbox"/> Manual Dexterity          | <input type="checkbox"/> Reaching                  | <input type="checkbox"/> Vision    |
| <input type="checkbox"/> Sitting                   | <input type="checkbox"/> Walking                   | <input type="checkbox"/> Sleeping  |
| <input type="checkbox"/> Speaking                  | <input type="checkbox"/> Standing                  | <input type="checkbox"/> Thinking  |
| <input type="checkbox"/> Working (Job Description) |  |                                    |
| <input type="checkbox"/> Other                     | <input type="text"/>                               |                                    |

If **major bodily functions** are affected, please select the functions from the menu below.

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Bladder               | <input type="checkbox"/> Digestive    | <input type="checkbox"/> Lymphatic                 |
| <input type="checkbox"/> Reproductive          | <input type="checkbox"/> Bowel        | <input type="checkbox"/> Endocrine                 |
| <input type="checkbox"/> Genitourinary         | <input type="checkbox"/> Hemic        | <input type="checkbox"/> Immune                    |
| <input type="checkbox"/> Musculoskeletal       | <input type="checkbox"/> Neurological | <input type="checkbox"/> Normal Cell Growth        |
| <input type="checkbox"/> Operation of an Organ | <input type="checkbox"/> Respiratory  | <input type="checkbox"/> Special Sense Organs/Skin |
| <input type="checkbox"/> Other                 | <input type="text"/>                  |  |

Please review your patient's job description with them to determine how, if at all, their impairment or limitation interferes with their ability to perform the functions listed on their job description.

If your patient is unable to perform functions listed on their job description, please **list them below and describe specifically how the limitations interfere with the ability to perform the functions.**

Provide any suggestions you have for your patient that may assist our office in providing possible accommodations to improve your patient's ability to perform the duties on their job description.

**Please be as specific as possible with your suggestions and how the suggestions will improve performance or ability for your patient to perform their job duties.**

**Duration of the accommodation:**

0-3 months  6-9 months  12 months

Please provide any additional information or list any questions or comments for the manager/supervisor or the Office of Human Resources:

Medical Professional Name:

Date:

Type of Practice/Medical Specialty:

Business Address:

Business Phone:

Business Fax:

Medical Professional Signature: \_\_\_\_\_

**Please return this form:**

**By mail:**

**Nova Southeastern University  
Office of Human Resources  
3100 SW 9th Avenue, Room 240  
Fort Lauderdale, Florida, 33315**

**By facsimile:  
(954)-262-6859**

**By e-mail:  
[ohr-ada@nova.edu](mailto:ohr-ada@nova.edu)**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.